**STATE OF CONNECTICUT**
**State Innovation Model**
***Equity and Access Council***

**Meeting Summary**
**Thursday, January 22, 2015**
**6:00-8:00 p.m.**

**Location**: CT Behavioral Health Partnership, Hartford Room (Suite 3D), 500 Enterprise Drive, Rocky Hill

**Members Present**: Linda Barry; Peter Bowers; Alice Ferguson; Kristen Hatcher; Deborah Hutton; Margaret Hynes; Gay Hyre; Roy Lee; Kate McEvoy; Robert Russo; Keith vom Eigen; Katherine Yacavone

**Members Absent**: Ellen Andrews; Maritza Bond; Christopher Borgstrom; Arnold DoRosario; Bonita Grubbs; Donald Stangler; Victoria Veltri; Robert Willig

**Other Participants**: Mark Schaefer; Katie Sklarsky; Adam Stolz

The meeting was called to order at 6:00 p.m.

## 1. Introductions

Linda Barry chaired the meeting. The council was briefed on new members appointed by the SIM Steering Committee today.

***New Members***
Rev. Bonita Grubbs – Replacing Barbara Headley until the CAB identifies a permanent replacement
Christopher Borgstrom – Replacing Darcey Cobbs-Lomax until she returns from leave
Dr. Arnold DoRosario – Replacing Dr. Erica Spatz
Kevin Galvin – Will fill in for Mr. Roy Lee as a voting member when Mr. Lee cannot attend

## 2. Public Comment

Sheldon Toubman remarked that the previous minutes inaccurately reflected his support for the current DSS-PMO protocol concerning planning alignment for development of safeguards. He pointed out that the protocol was undergoing revisions. Mr. Toubman remarked that the protocol states that a preponderance of the Equity and Access Council are consumer advocates, which he stated is not accurate. Mr. Toubman also expressed dissent regarding the Council's substitution policy. To date, non-appointed persons have not served as substitutes for EAC members. Mr. Toubman stated that the Steering Committee does not follow this practice. Mark Schaefer clarified that the Steering Committee had not, before today, set any provisions for substitute membership on Councils. Today, the Steering Committee appointed voting substitutes on an interim basis.

The Steering Committee allows state agencies to delegate to alternate members since the seat is held by the organization, not the individual.

## 3. Minutes

At this point the council achieved a quorum. The Council discussed past meeting minutes.

***September 18, 2014***
The September minutes will be adjusted to reflect the presence of Margaret Hynes. With that change, the minutes were approved unanimously. Katherine Yacavone and Alice Ferguson abstained because they were not present at the September meeting.

***November 13, 2014***
The November minutes will be adjusted to reflect the presence of Kristen Hatcher. With that change, the minutes were approved unanimously. Alice Ferguson abstained because she was not present at the meeting.

***December 18, 2014***
The Council members approved the December minutes unanimously

## 4. Interview Themes

***Summary of themes from EAC member interviews***
Adam Stolz of Chartis reviewed themes from the Council member interviews. Chartis met with fifteen of the twenty Council members. Chartis will conduct interviews with the four new Council members. The interviews focused on the Equity and Access Council's context and purpose, the current climate surrounding equity and access in Connecticut and under SIM, and ways to maximize participation in the Council. Adam Stolz commented on the importance and value of the discussions. This section of the presentation was broken down into four themes that resulted from the Council member interviews.

*Theme 1: "It is critical that the EAC's charge, scope, and roadmap for completing its work be clearly articulated."*

*Theme 2: "Actively participating in the EAC can be challenging for some members- for reasons of logistics and/or perceived lack of knowledge on the topics."*

*Theme 3: "Introduction of value-based payment methods has the potential to mitigate some of the core challenges that underserved populations face in the current fee-for-service system; however, it won't solve all of today's challenges, and a range of views exist about whether it is likely to generate new ones."*

*Theme 4: "A range of other issues, in addition to those explicitly assigned to the EAC, pose challenges for equity and access in Connecticut's historical and future healthcare landscape."*

## 5. The EAC's Role

***Discussion of the EAC'S charge and role within SIM***
Mr. Stolz described the vision of the CT State Innovation Plan, the initiatives to be completed in the SIM Model Test phase, and the SIM implementation activities and structure. He reviewed the role of the EAC as one of five Councils under the oversight of the Program Management Office and the HISC.

***Overview of how equity and access are being addressed elsewhere within SIM and how the EAC's role is distinct***
Mr. Stolz reviewed the two phases of work that the EAC's charter describes. Phase I is focused on issuing recommendations for preventing, detecting, and responding to underservice and patient selection. Phase II is broad and may result in recommendations that address gaps or disparities in healthcare quality or access. Phase II could extend throughout SIM. The EAC could design a way to monitor the impact of SIM on equity and access over time, serving as a "guardian" of these important issues.

The topic was opened up for discussion. Linda Barry asked if the EAC created the measurement and monitoring methods, would the Council have any enforcement powers? Mr. Stolz suggested that while the Council does not have any executive authority the group has influence by way of bringing issues to light, proposing solutions for adoption, and forging consensus. Mr. Toubman noted that it has already been determined in the SIM plan that if a provider does not meet certain benchmarks, they will not be eligible for value-based incentive payments. Keith vom Eigen suggested the EAC is an advisory group that submits recommendations to the Steering Committee and the Steering Committee makes decisions on the issues.

Kate McEvoy recommended that monitoring needs to be substantive, and that a breadth of strategies be used such as a mystery shopper, ombudsman, and audits. Ms. McEvoy also hoped that the Council would not feel constrained to focusing on quality measures. Dr. Barry also shared this sentiment.

Katherine Yacavone asked if the timeline for delivering recommendations is the same for all SIM Councils, or whether Council recommendations build off of each other. Mr. Stolz responded that the Councils are following different schedules to reflect differences in subject matter and timing of SIM activities. For example, the Quality Council is well underway, whereas the HIT Council just launched its work. Dr. Schaefer explained that there are a number of related work streams, though they are not all interdependent.

## 6. Rationale for Safeguards as Part of Payment Reform

Mr. Stolz defined "safeguards" in this context as referring to the EAC's recommendations for prevention, detecting, and responding to underservice and patient selection, and led a discussion about the rationale for safeguards from different perspectives

***Potential benefits to consumers***
Hypotheses presented about the consumer rationale for safeguards included: wanting access to appropriate services, providers, and information about available and appropriate interventions. Gaye Hyre suggested consumers want "access in a timely manner." Ms. Yacavone added, "access to a whole spectrum of providers." Ms. McEvoy suggested a clarification of the term "access." Ms. McEvoy suggested the Council identify its set of assumptions regarding that term and offered that access could imply physical, cultural competence or other factors. Alice Ferguson asked if consumer choice is a factor in access.

***Potential benefits to providers***
Hypotheses presented about the provider rationale for safeguards included: wanting to align reimbursement rules with why they went into medicine, medical ethics, and their mission to provide the best patient care. Providers want the playing field to be level, with no incentive to cheat, and a market advantage for ACOs that demonstrate appropriate care and deliver access to the right services.

Ms. Hyre suggested "and timely" be added to provider perspective. Ms. Hyre referenced a previous discussion where "timely" can be at a point outside the hours of 8:00a.m and 4:00p.m. Dr. vom Eigen commented on the substance of quality incentives and how tricky measurement can be.

***Potential benefits to payers***
Hypotheses presented about the payer rationale for safeguards included: wanting to act in the consumers' interest and improve their health, wanting to comply with applicable laws that prohibit certain activities, and wanting to incent providers to take on the most challenging, most expensive patients. The payer will ostensibly want to prevent patient under-service that would result in higher costs over time.

Robert Russo brought up the element of the noncompliant patient. Is the patient's substandard care driven by the provider, payer, or by the patient's noncompliance? Ms. Hyre brought up instances where a provider will order expensive, unnecessary tests in order to qualify a patient to be insured for the test they need. Dr. vom Eigen pointed out that these instances are often caused by issues in communication between the provider and payer. Dr. vom Eigen said this could be solved by putting a medical professional who understands the nuances of the medical profession on the payer side of communications.

A discussion ensued between members regarding barriers to care and factors that lead to patient "noncompliance." Ms. Ferguson suggested a checklist for providers to complete in order to help distinguish those patients who have barriers to care from those who are noncompliant.

## 7. **A Design Framework for the EAC's Recommendations**

Mr. Stolz introduced a framework consisting of two types of safeguards: one safeguard involving payment design features and the other consisting of supplemental safeguards.

Mr. Stolz led discussion of payment design features. He described the components of value-based payment methods. Value-based payment involves patient attribution, the expected total cost of each patient, payment calculation, and how payments are distributed.
Dr. vom Eigen remarked that it could be difficult to know who your population is as a provider in the current, retrospective system used by Medicare. It was noted that Medicare has recently introduced a new shared savings program track that utilizes prospective attribution. Peter Bowers highlighted the importance of knowing your population in order to be accountable for them. Kate McEvoy discussed the tension between creating clear up front attribution and provider continuity on the one hand, and ensuring patient choice on the other hand. She remarked that Medicaid uses retrospective attribution; they moved away from a managed care model in favor of more person-centered care, an important aspect of which is letting patients "vote with their feet."

Ms. Yacavone commented it is hard to be responsible when a patient is not a consistent user of a given provider. Ms. Yacavone remarked that a two-way partnership between provider and patient involving patient choice and patient responsibility is important. Ms. Ferguson remarked that patient attribution should be a major component of any solution that seeks to address access and quality. She noted that doctor continuity is of great value to the patient's overall health. Dr. vom Eigen and Dr. Bowers discussed the team aspect of care where many providers care for one patient, and the challenge of monitoring attribution and payments to prevent duplication. Dr. vom Eigen commented that the easiest way to understand your population, as a provider, might be to examine to whom you provide prescriptions.

Mr. Stolz led discussion of supplemental safeguards. This sparked a discussion concerning the term "enforcement." Dr. Bowers suggested that "enforcement" was potentially inconsistent with the spirit in which SIM is seeking adoption of solutions by consensus. He suggested "accountability" instead. Conversely, Kristen Hatcher suggested that enforcement accurately portrayed the weight of noncompliance and sent the appropriate message. Ms. Hyre remarked that the bottom line is to ensure noncompliance does not occur.

Mr. Stolz presented a list of research expanded upon by Katie Sklarsky of Chartis, who began reviewing existing methodologies in use today for patient attribution.

***Formulation of EAC work streams and supporting design groups to conduct inquiry and propose solutions***

Mr. Stolz proposed a process for the Council to utilize four design groups to work offline to evaluate each solution area in the framework, in order to better inform Council discussion on each area. Council members were asked to pick one or more design groups in which they will participate on an ongoing basis. This will entail up to two one-hour design workshops conduct by conference call between now and mid-March, in addition to background reading. All design sessions will be open to all Council members, in addition to being open to the public. Several Council members signed up for design groups. The Council proposed lunchtime as the best time to hold design workshops by conference call.

Dr. Barry asked the council to extend the meeting for five minutes for comments. The council discussed substitute attendee policies. It was decided this issue would not be resolved and would be tabled for a later discussion. Linda Barry motioned to adjourn. Gaye Hyre seconded. The motion passed unanimously and the meeting adjourned at 8:05pm.